Having problems getting health care or medicine in TennCare?

Use this page **only** to file a
TennCare Medical Appeal.

Need help filing a medical appeal?
- Call **1-800-878-3192** for free.

Versión en español atrás

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing.

1. WHO is the person that wants to appeal?

Full name _____ Date of birth____/____/_____

Social Security Number_____-_____-_____ OR number on their TennCare card _____

Current mailing address_____

City_____ State _____ Zip Code_____

The name of the person we should call if we have questions about this appeal:_____

A daytime phone number for that person (_____)_____-_____

2. WHO filled out this form?

If **not** the person that wants to appeal, tell us your name._____

Are you a: ____ Parent, relative, or friend ____ Advocate or attorney ____ Doctor or health care provider

3. WHAT is the appeal for? (Place an **X** beside the right answer below.)

___ Want to **change health plans.** (Fill out **Part A** on page 2.)

___ **Need care or medicine.** (Fill out **Part B** on page 2.)

___ Have **bills for care or medicine** you think TennCare should pay for. (Fill out **Part C** on page 2.)

4. Do you and your doctor think you <u>have an emergency</u>?

Usually, your appeal is decided within **90 days** after you file it. BUT, **if you have an emergency,** you may not be able to wait 90 days. **An emergency means if you <u>don't</u> get the care or medicine sooner than 90 days:**

- You will be at risk of serious health problems OR you may die.
- OR, it will cause serious problems with your heart, lungs, or other parts of your body.
- OR, you will need to go into the hospital.

Do you and your doctor think you have an emergency? If so, you can ask TennCare for an emergency appeal. **Have your doctor sign below** saying that this appeal is an emergency. What if your doctor **doesn't** sign below but **you ask** for an emergency appeal? Then, **we'll ask your doctor** to tell us in writing if your appeal is an emergency. What if your doctor says your appeal **isn't** an emergency? Then, we'll decide your appeal within 90 days. An appeal for care or medicine you've already gotten will **not** be treated as an emergency.

FOR PHYSICIAN USE ONLY: I certify under penalty of perjury that I am the treating physician of the patient on behalf of whom this medical appeal is filed and that this appeal is an **emergency.** If this patient is required to wait 90 days for this care, s/he is at risk of serious health problems or death, severe impairment of bodily organs or parts, or hospitalization. I understand that any intentional act on my part to provide false information is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act.

Physician Signature:_____ Date:_____

Tennessee License Number:_____

KEEP READING. There is **1 more page** for you to fill out.

5. Tell us WHY you want to appeal this problem. Include any mistake you think TennCare made. AND, send copies of any papers that you think may help us understand your problem.

_____

_____

_____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans.

Name of health plan you want _____

OR, if you want TennCare to pick your new health plan, place an X here. ____

Part B. Need care or medicine.

What kind - be specific _____

What's the problem? ___ Can't get the care or medicine at all.
___ Can't get as much of the care or medicine as I need.
___ The care or medicine is being cut or stopped.
___ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? ___Yes ___No If yes, doctor's name _____

Have you asked your health plan for this care or medicine? ___Yes ___No If yes, when? _____

What did they say? _____

Did you get a letter about this problem? ___Yes ___No If yes, the date of the letter _____

Who was the letter from? _____

Are you getting this care or medicine from TennCare now? ___ Yes ___ No

Do you want to see if you can keep getting it during your appeal? ___ Yes ___ No

Does your doctor say you still need it? ___ Yes ___ No If yes, doctor's name _____

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine_____ Name of doctor, drug store, or other place that gave you the care or medicine _____ Their phone number (_____)_____-_____

Their address _____

Did you **pay for the care or medicine and want to be paid back?** ___ Yes ___ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** ___ Yes ___ No If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know). _____

HOW to file your medical appeal

Make a copy of the completed pages to keep.

Then, **MAIL** these pages and other facts to:

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

OR, **FAX** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **PHONE**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

Rev: 28Dec05

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, or disability.
If you think you've been treated unfairly, call the Family Assistance Service Center for free at **1-866-311-4287.**